PEPFAR

External Engagement Meeting
March 16, 2016

PEPFAR/Tanzania

PEPFAR

COP 2016 Overview

TOOLS AND PROCESSES

Country Operation Plan (COP) 2016 Summary

What is a PEPFAR COP?

- The Country Operation Plan is a document to inform stakeholders about funding from the U.S. Government for the PEPFAR program supporting the national response to HIV and AIDS.

Who is the audience for the PEPFAR Tanzania COP 2016?

- All stakeholders in the national response to HIV and AIDS, including the U.S. Congress and American people as well as the Government of Tanzania and the Tanzanian people

Which information is included in the COP?

- A narrative overview of the national response to HIV and AIDS and the role of the PEPFAR program within that response
- Annual PEPFAR Work Plans and Budgets for Fiscal Year 2016/17
- Anticipated PEPFAR Results (Targets) for FY 2016/17
- Supplementary data tables and documents to support the analysis and strategic planning for the budgeted funds

COP 2016 Tools

Which documents and tools are included in the COP?

1. Strategic Direction Summary (SDS)
   - Narrative to support the strategy, priorities, work plan, and budget
2. Data Pack
   - Used for analyzing epidemiological data
3. Sustainability Index and Dashboard (SID)
   - Measures sustainability across 15 elements of the national response to HIV and AIDS
4. Systems and Budget Optimization Review and Template (SBOR)
   - Prioritizes budgets for program supporting activities
5. PEPFAR Budget Allocation Calculator (PBAC)
   - Uses expenditure data to generate budget code allocations
6. EA Data Navigation Tool and EA-Epi Comparison Tool
   - Uses Expenditure Analysis (EA) data to budget for planned results
7. SIMS Action Planner
   - Site Improvement and Monitoring System for PEPFAR

COP 2016 Timeline

What is the timeline for writing the COP?

- COP 2016 guidance was completed in December 1, 2015
- COP 2016 technical considerations were completed on February 2, 2016
  - Both documents are available online at: www.pepfar.gov/reports/guidance/index.htm
- PEPFAR Tanzania and the PS Ministry of Health met with PEPFAR senior leadership in Washington, D.C., March 1-4 to share draft budgets, targets, and strategies and receive guidance on the way forward
- March 16 Meeting with External Stakeholders is designed to share draft plans and strategies, receive feedback and input, and inform the final COP submission
- April 14: the COP is submitted to the Office of the Global AIDS Coordinator (OGAC)
- May 18-20: the submitted COP is reviewed in Johannesburg with PEPFAR senior leadership and submitted for final approval by OGAC

COP 2016 Processes

How is the COP completed?

- Sharing of tools with government of Tanzania counterparts began in January 2016 and have informed the details in the Data Pack
- Sharing of guidance documents with civil society and other stakeholders also began in January 2016
- PEPFAR technical staff work with government counterparts to complete the standard tools, prioritize interventions, geographies, and populations
- PEPFAR HQ and Country Team draft a work plan and balanced budget to share with external stakeholders
- External stakeholders review and submit feedback and recommendations on the draft plan
- PEPFAR Country Team deliberates on feedback to produce the COP
- Submitted COP is reviewed by PEPFAR HQ and external stakeholders in Johannesburg for final approval

COP Terminology for Priority Areas

- **"Scale-up to Saturation"** = High burden areas that can achieve 80% of all PLHIV on ART by 2017 with increased effort

- **"Scale-up Aggressive"** = High burden areas that can achieve 80% of all PLHIV on ART by 2018/19 with increased effort

- **"Sustained"** = Lower burden areas that will reach 80% of all PLHIV on ART by 2020 without increased effort

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COP 2016 Overview

STRATEGIES AND PRIORITIES

Continuing Strategies and Priorities for COP 2016

1. Reach 80% treatment coverage in the highest burden districts first
2. Rapidly improve pediatric case finding and retention
3. Focus HIV testing on the highest prevalence and at-risk populations:
   - Sex workers
   - Men who have sex with men
   - Injecting drug users
   - Adolescent girls and young women
   - Orphaned and malnourished children
4. Develop innovative prevention interventions for adolescent girls and young women
5. Scale up viral load access
6. Continue expanding VMMC to 80% coverage levels
7. Share quarterly data with CSOs at meetings in Dar es Salaam

New Strategies and Priorities for COP 2016

1. Adopt Test and START guidelines to treat all PLHIV
   - Phased implementation
2. Implement 6-monthly clinical visits for stable patients
3. Support 3-monthly ARV refills in community settings
4. Expand HIV testing focus to include:
   - Suspected TB cases
   - Sexually transmitted infection (STI) patients
   - Expanded partner notification program of new HIV+ patients
   - Incentivized Peer Network Case Finding Work with the Global Fund on implementing recommendations from the OIG audit to improve the supply chain for medicines
5. Develop Unique Identifier for Health
   - Track HIV patients from testing through to treatment and retention
6. Conduct Quarterly CSO meetings in regional settings

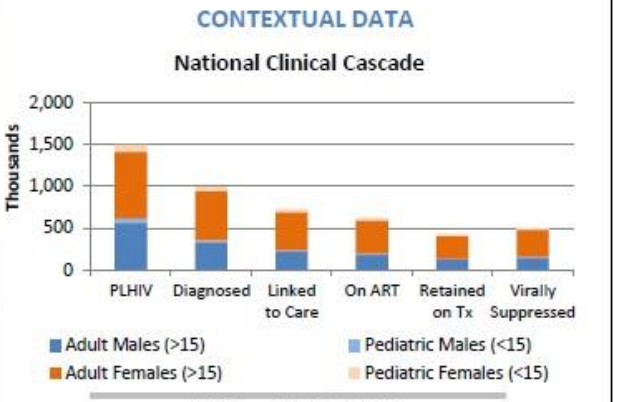
Sustainability Analysis for Epidemic Control: Tanzania

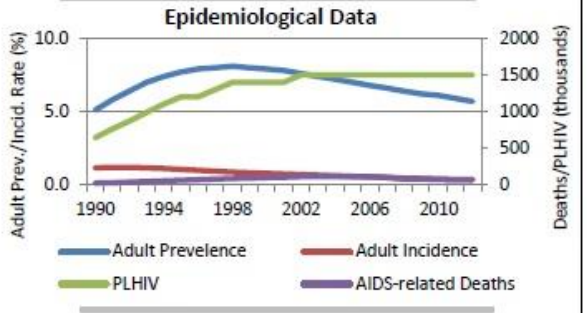
Epidemic Type: Generalized
Income Level: Low-income
PEPFAR Categorization: Long-term Strategy
PEPFAR COP 16 Planning Level: $430,000,000

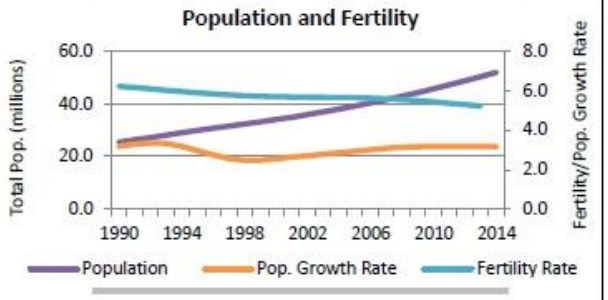
SUSTAINABILITY DOMAINS and ELEMENTS

	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	4.43			
2. Policies and Governance	3.85			
3. Civil Society Engagement	4.17			
4. Private Sector Engagement	4.86			
5. Public Access to Information	5.00			
National Health System and Service Delivery				
6. Service Delivery	3.38			
7. Human Resources for Health	5.00			
8. Commodity Security and Supply Chain	4.94			
9. Quality Management	5.19			
10. Laboratory	3.33			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	1.94			
12. Technical and Allocative Efficiencies	3.17			
Strategic Information				
13. Epidemiological and Health Data	4.70			
14. Financial/Expenditure Data	4.58			
15. Performance Data	5.99			

CONTEXTUAL DATA







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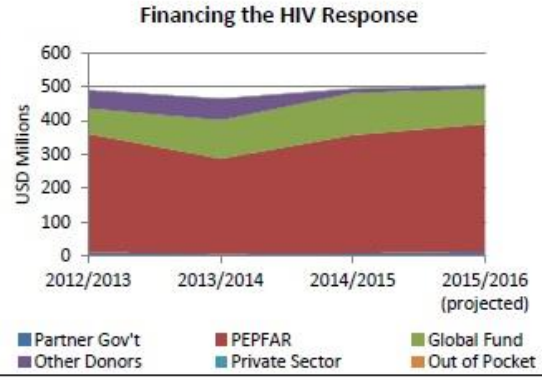
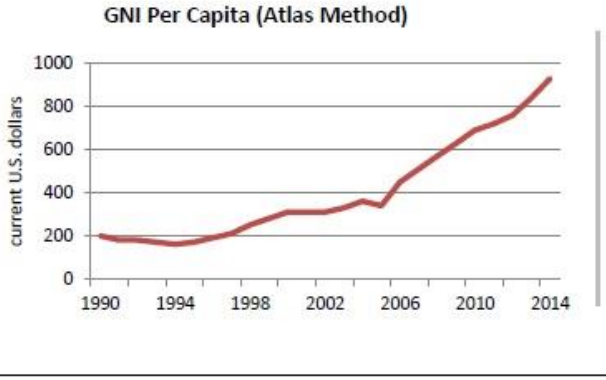
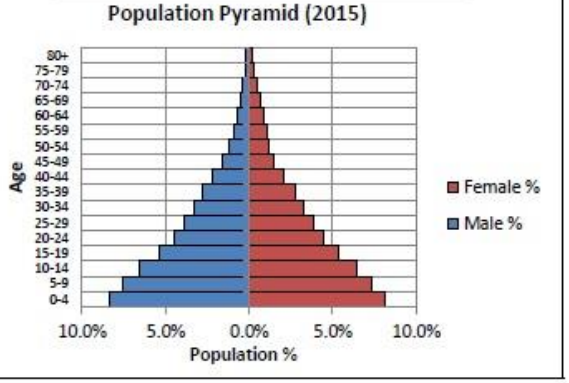






Sustainability Strengths

- Public access to information has been steadily improving in:
  - Open data commitments by government leadership
  - Improved information systems for health management and supply chain, with online web portals
  - Big Results Now initiative to track sectoral performance indicators

- Performance data are more readily available in:
  - Nationwide Health Management Information System using the DHIS2
  - Electronic Care and Treatment Center database
  - Electronic Logistics Management and Information System
  - Human Resources for Health Information System

Sustainability Vulnerabilities

Proposed priority attention for COP 2016:

1. Service delivery environment to implement Test and START
2. HRH, data systems, lab for service delivery models
3. Adult and pediatric ART retention
4. Patient tracking system for improved HIV testing services and continuum of care, treatment and viral suppression
5. Financing for the HIV commodity gap (*e.g.*, ARVs, lab reagents), improved DRM, and improvements in the commodity management system

SBOR: Programmatic Gaps and Response

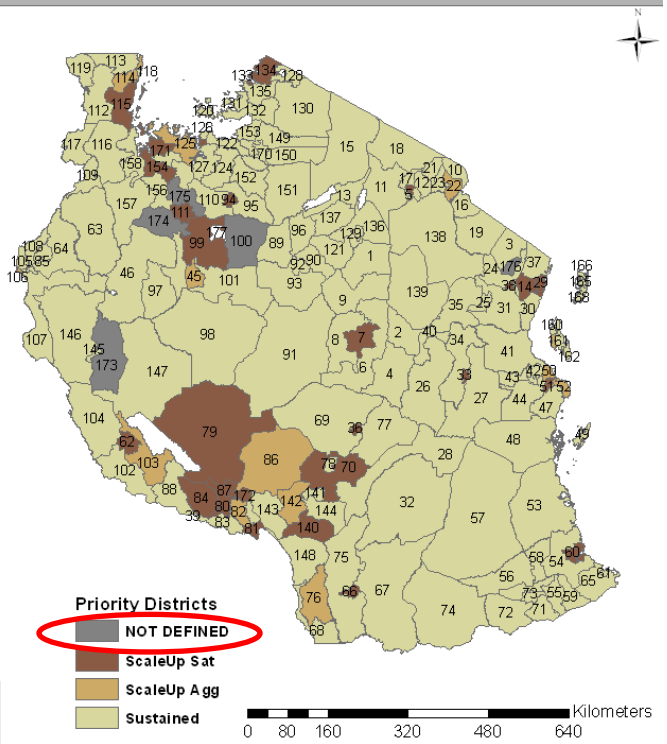
Programmatic Gap	Sample Systems Barrier	Outcomes
Alternative Service Delivery Models	Lack of functionality within patient tracking systems to support differentiated service delivery models	• Increased HIS capacity to adapt to service delivery model needs
Adult and Pediatric Retention	Inadequate government systems and tools for facility-community service linkages	• QI teams functional and involved in facility community linkage
HIV Testing Services	Inadequate policy guideline to support HTS (age of consent for Testing)	• Lower age of consent and disclosure policy adopted and implemented
ARV and Commodities	Inefficient system for distribution of commodities under new service delivery platform	• Supply chain system redesigned using financial and service data to improve distribution under new service delivery models

COP15 and New Council Prioritization Categories

TANZANIA: ORIENTATION TO DISTRICT NAMES AND PRIORITIZATION LEVELS, FY16

ID	District	ID	District	ID	District	ID	District
1	Kondoa DC	51	Ilala MC	101	Uyui DC	151	Meatu DC
2	Kongwa DC	52	Temeke MC	102	Kalambo DC	152	Maswa DC
3	Lushoto DC	53	Kilwa DC	103	Sumbawanga DC	153	Busega DC
4	Mpwapwa DC	54	Lindi DC	104	Nkasi DC	154	Geita DC
5	Arusha City Council	55	Newala DC	105	Kigoma DC	155	Nyanghwale DC
6	Charmwino DC	56	Nachingwea DC	106	Kigoma Ujiji MC	156	Mbongwe DC
7	Dodoma MC	57	Liwale DC	107	Uvinza DC	157	Bukombe DC
8	Bahi DC	58	Ruangwa DC	108	Buhigwe DC	158	Chato DC
9	Chemba DC	59	Tandahimba DC	109	Kakonko DC	159	Kaskazini A
10	Rombo DC	60	Lindi MC	110	Shinyanga DC	160	Kaskazini B
11	Monduli DC	61	Mtwara Mikindani MC	111	Kahama TC	161	Kati
12	Meru DC	62	Sumbawanga MC	112	Karagwe DC	162	Kusini
13	Karatu DC	63	Kibondo DC	113	Missenyi DC	163	Magharibi
14	Muheza DC	64	Kasulu DC	114	Bukoba DC	164	Mjini
15	Ngorongoro DC	65	Mtwara DC	115	Muleba DC	165	Wete
16	Mwanga DC	66	Songea MC	116	Biharamulo DC	166	Micheweni
17	Arusha DC	67	Namtumbo DC	117	Ngara DC	167	Chake Chake
18	Longido DC	68	Nyasa DC	118	Bukoba MC	168	Mkoani
19	Same DC	69	Iringa DC	119	Kyerwa DC	169	Tarime TC*
20	Moshi MC	70	Mufindi DC	120	Ukerewe DC	170	Bariadi TC
21	Siha DC	71	Masasi DC	121	Hanang DC	171	Geita TC
22	Moshi DC	72	Nanyumbu DC	122	Magu DC	172	Busokelo DC
23	Hai DC	73	Masasi TC	123	Nyamagana MC	173	Nsimbo DC
24	Korogwe DC	74	Tunduru DC	124	Kwimba DC	174	Ushetu DC
25	Handeni TC	75	Songea DC	125	Sengerema DC	175	Msalala DC
26	Kilosa DC	76	Mbinga DC	126	Ilemela MC	176	Bumbuli DC
27	Morogoro DC	77	Kilolo DC	127	Misungwi DC	177	NzegaTC*
28	Kilombero DC	78	Mafinga TC	128	Tarime DC		
29	Tanga City Council	79	Chunya DC	129	Babati TC		
30	Pangani DC	80	Mbeya DC	130	Serengeti DC		
31	Handeni DC	81	Kyela DC	131	Musoma DC		
32	Ulanga DC	82	Rungwe DC	132	Bunda DC		
33	Morogoro MC	83	Ileje DC	133	Musoma MC		
34	Mvomero DC	84	Mbozi DC	134	Rorya DC		
35	Kilindi DC	85	Kasulu TC	135	Butiama DC		
36	Iringa MC	86	Mbarali DC	136	Babati DC		
37	Mkinga DC	87	Mbeya City Council	137	Mbulu DC		
38	Korogwe TC	88	Momba DC	138	Simanjiro DC		
39	Tunduma*	89	Itamba DC	139	Kiteto DC		
40	Gairo DC	90	Singida DC	140	Njombe TC		
41	Bagamoyo DC	91	Manyoni DC	141	Makambako TC		
42	Kibaha TC	92	Singida MC	142	Wanging'ombe DC		
43	Kibaha DC	93	Kyungi DC	143	Makete DC		
44	Kisarawe DC	94	Shinyanga MC	144	Njombe DC		
45	Tabora MC	95	Kishapu DC	145	Mpanda TC		
46	Kaliua DC	96	Mkalama DC	146	Mpanda DC		
47	Mkuranga DC	97	Urambo DC	147	Mlele DC		
48	Rufiji DC	98	Sikonge DC	148	Ludewa DC		
49	Mafia DC	99	Nzega DC	149	Bariadi DC		
50	Kinondoni MC	100	Igunga DC	150	Itilima DC		

* Missing prioritization level in DATIM



Names and boudary representation are not necessarily authoritative.
UNCLASSIFIED

Source: IMPATT.PRIORITY_SNU(Oct. 2015 - Sept. 2016), DATIM 02/08/2016

Council	COP 2015 Prioritization Level	2014 PLHIV	2014 Prevalence (%) all ages	2015 PLHIV	2015 Prevalence (%) ages 15-49
Ushetu DC	Undefined: now scale up aggressive			10,398	6.6
Msalala DC	Undefined: now scale up aggressive			10,051	6.9
Nsimbo DC	Undefined: now sustained			4,580	6.1
Bumbuli DC	Undefined: now sustained			1,412	1.5

"Not Defined" are new councils; included in COP 2016 prioritization process

Proposed Updates/Changes in Council Prioritization – first step in iterative process requires review after costing

- 6 scale up councils reached >80% coverage; programmatic approach will be sustained (still classified as scale-up)
- 2 sustained councils now scale up - PLHIV ranking is now above the current 40 council cut-off (Shinyanga DC and Ilemela MC)
- 1 aggressive council now saturation - reached >50% coverage (Rungwe DC)
- Kahama DC, a scale up-aggressive council split into two; Both are scale up aggressive (Msalala and Ushetu DC)
- 2 new councils are sustained - PLHIV ranking is below the current cut-off (2 councils, Nsimbo DC and Bumbuli)
- Retained prioritization for two KP councils (Mjini and Magharibi in Zanzibar)

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COP 2016 Plan for HIV Epidemic Control

90-90-90 BY 2020

1st 90

90% of all PLHIV know their status

1st 90: Key Achievements and Opportunities

Achievements to Date:

- Task shifting approved to allow Community Health Workers and lay counselors to provide counseling and testing services and dispersing ARVs
- Reduced number of supported low-yield sites by 2,786 (49%) in Q1 2016
- Improved testing yield from 4.4% in FY2014 to 5.4% in Q1 2016
- Strengthened case finding for infected children through OVC platforms
- Developed standardized M&E tools for KP services

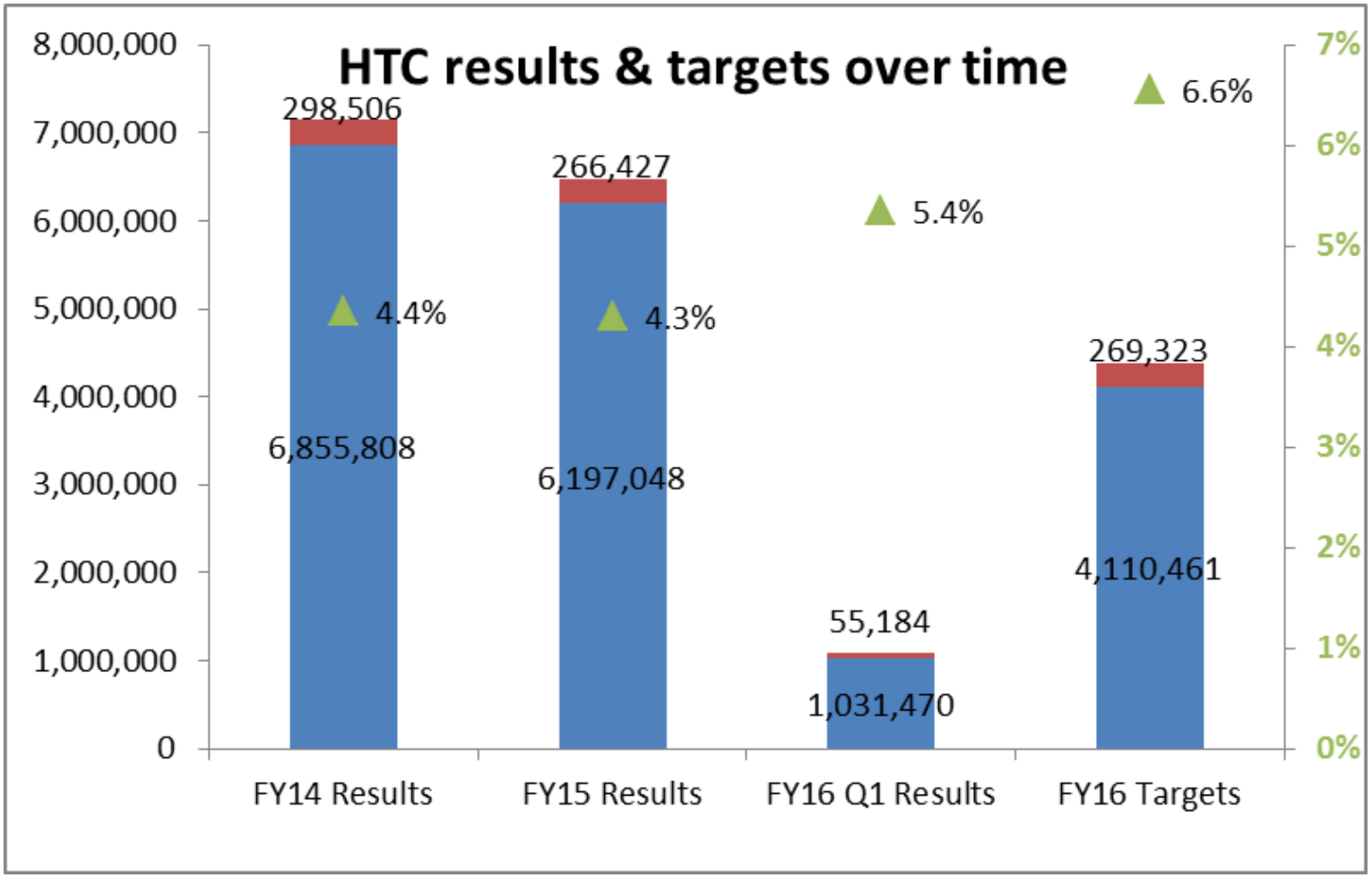
Challenges and Opportunities for COP 2016:

- Inadequate case detection rate to reach treatment targets and epidemic control, including among KPs
- Finding the men as soon as we can guarantee they will get ART

FY 2016 HTC aims for more efficient testing:

Improved yield, but lower than yield target

Testing has been more targeted but still needs to improve!



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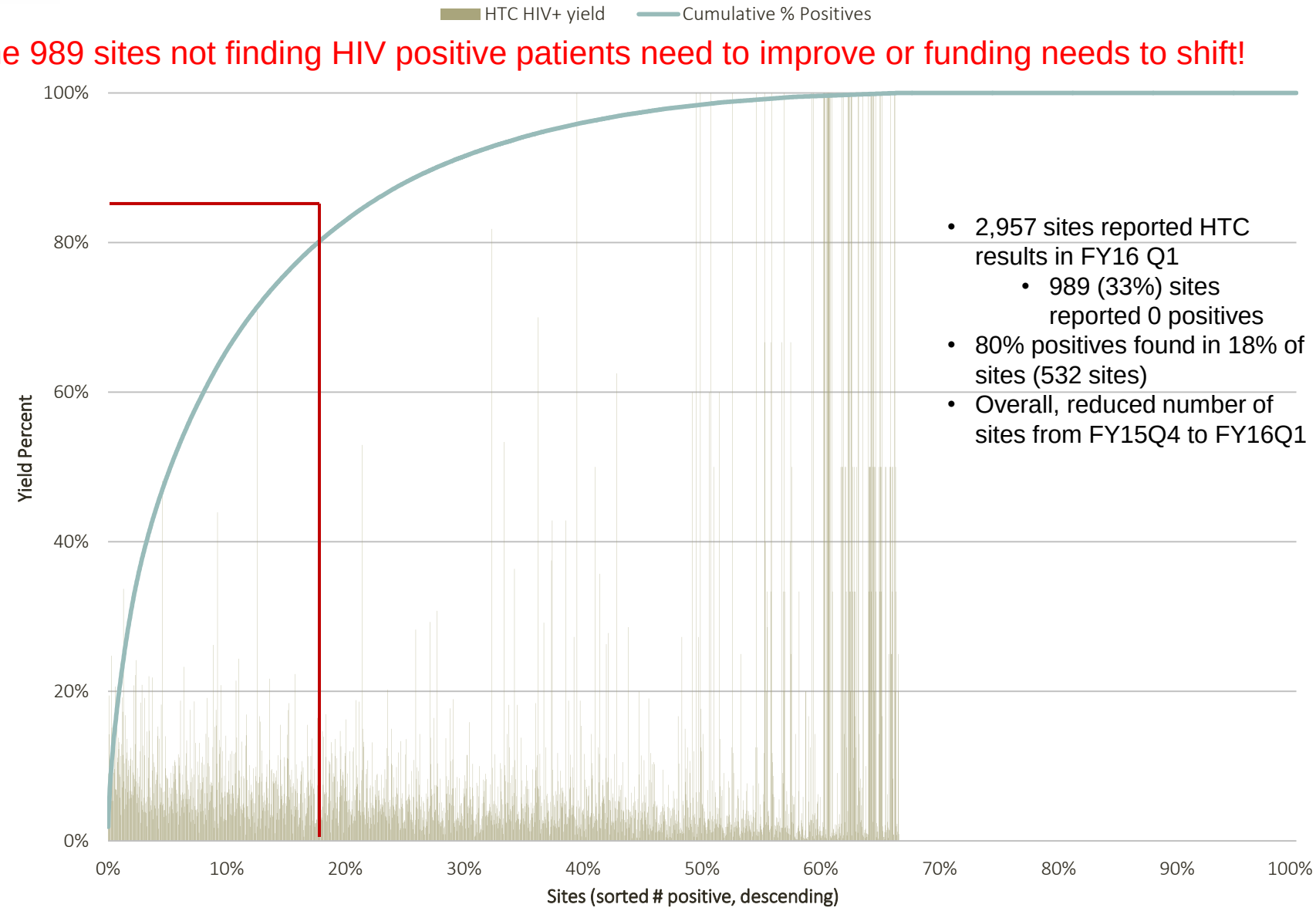
FY16 Q1 HTC Yield by Site and Cumulative Number of Positives Identified

The 989 sites not finding HIV positive patients need to improve or funding needs to shift!



- 2,957 sites reported HTC results in FY16 Q1
  - 989 (33%) sites reported 0 positives
- 80% positives found in 18% of sites (532 sites)
- Overall, reduced number of sites from FY15Q4 to FY16Q1

Findings from Tanzania HTS Partner Notification Study

- The study examined feasibility, acceptability and effectiveness and partner notification in context of routine facility based HTS
- 360 Index clients identified, 438 sexual partners
  - ❖ 318 (73.2%) were spouses
  - ❖ 248 (56.6%) sexual partners were successfully referred to HTS
  - ❖ 234 (95.5%) of the successfully referred partners were reached through passive referrals
  - ❖ 238 (90.0%) received HTS
  - ❖ 61.8% (53.5% male, 67.9% female) tested positive for HIV

Conclusion

- Findings present strong evidence in favor of integrating partner notification and testing into facility based HTS in Tanzania

COP 16: Innovations to Reach First 90

Plans for increasing yield and numbers diagnosed now and in COP 16:

- Scale up partner notification and testing (new)
  - TZ CROI presentation showed high uptake and very high yield
- Incentivize social network testing (new)
- Test TB suspects (new), STI patients (new), and OVC
- Targeted community-level demand creation for testing
- Address issues/policies around stigma

Impact of Unique Identifier on First 90:

Enable de-duplication of positive tests & tracking of linkages

2nd 90

90% of all identified PLHIV are on ART

2nd 90: Achievements and Opportunities

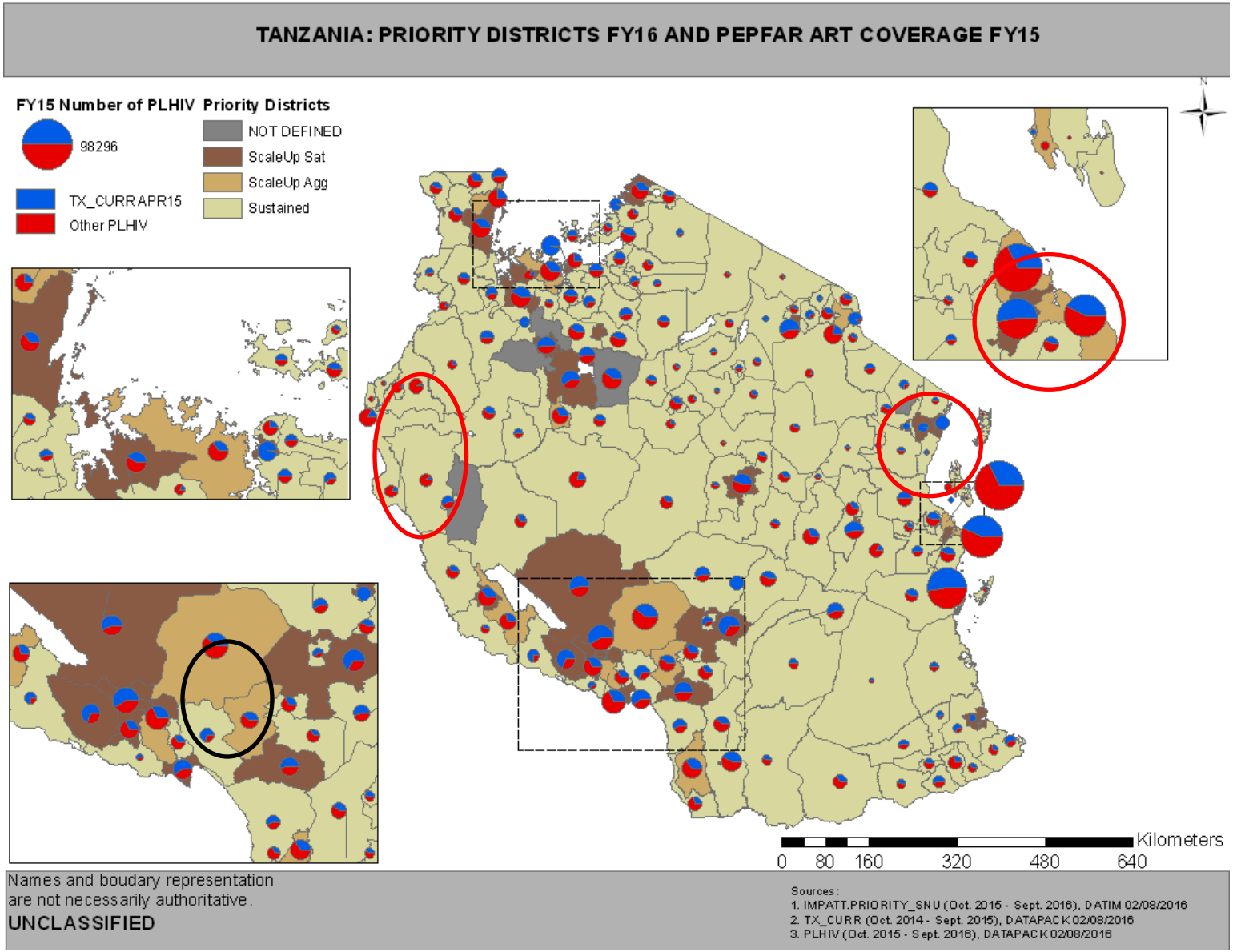
Achievements

- ACT achieved 54% of its two-year target for children on ART
- National implementation of PMTCT Option B+ with over 97% coverage
- Adoption of Test and Start for all populations in DREAMS districts
- Improved collaboration between facility and community to strengthen patient linkages to care, retention and active tracking of Lost to Follow-up (LTFU) clients

Challenges/Opportunities

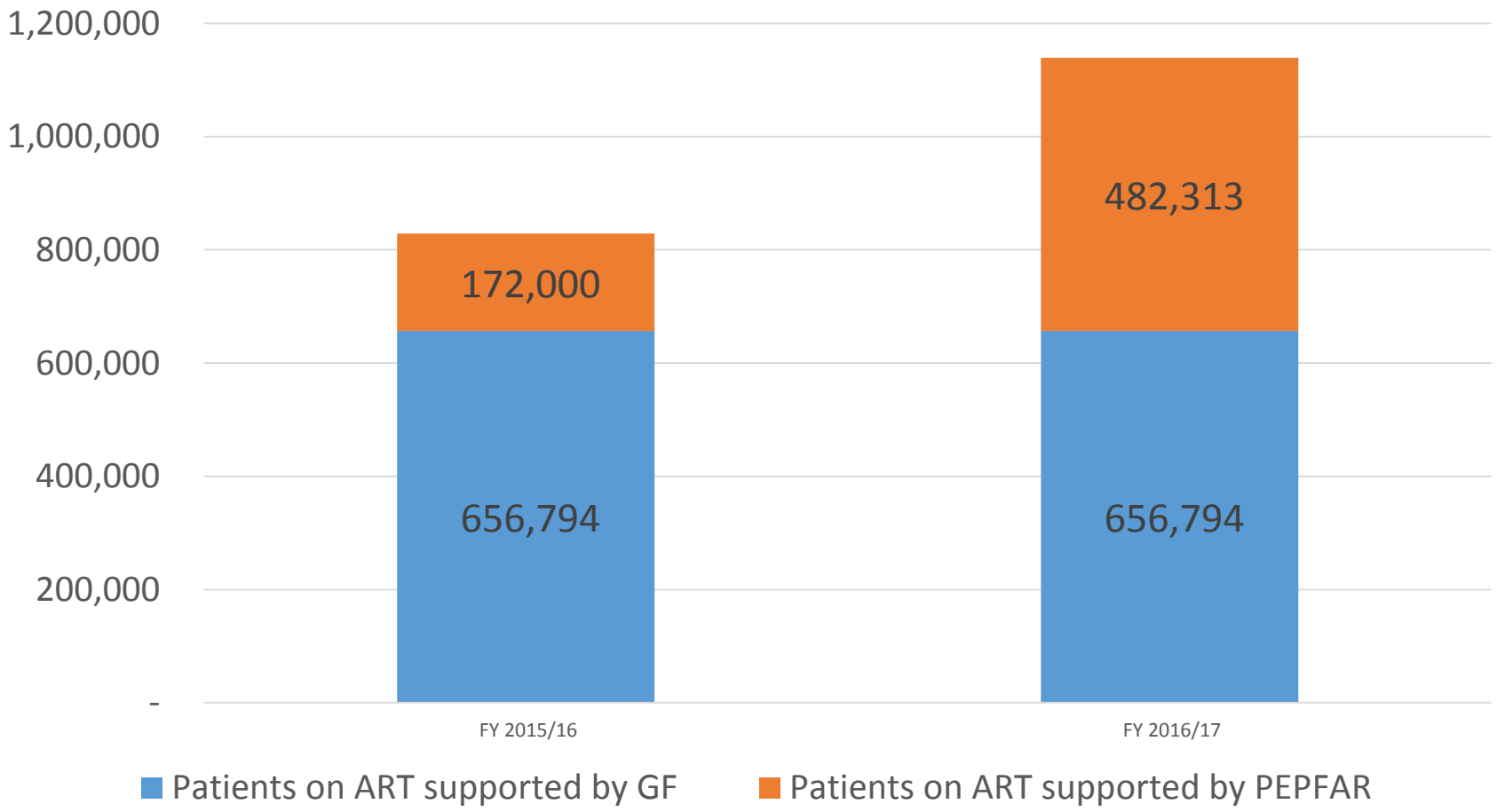
- Need to ensure supply chain implications are addressed during all stages of planning for new service delivery models

Unmet ART need by Council Prioritization (APR)



National ARV forecast and PEPFAR programming

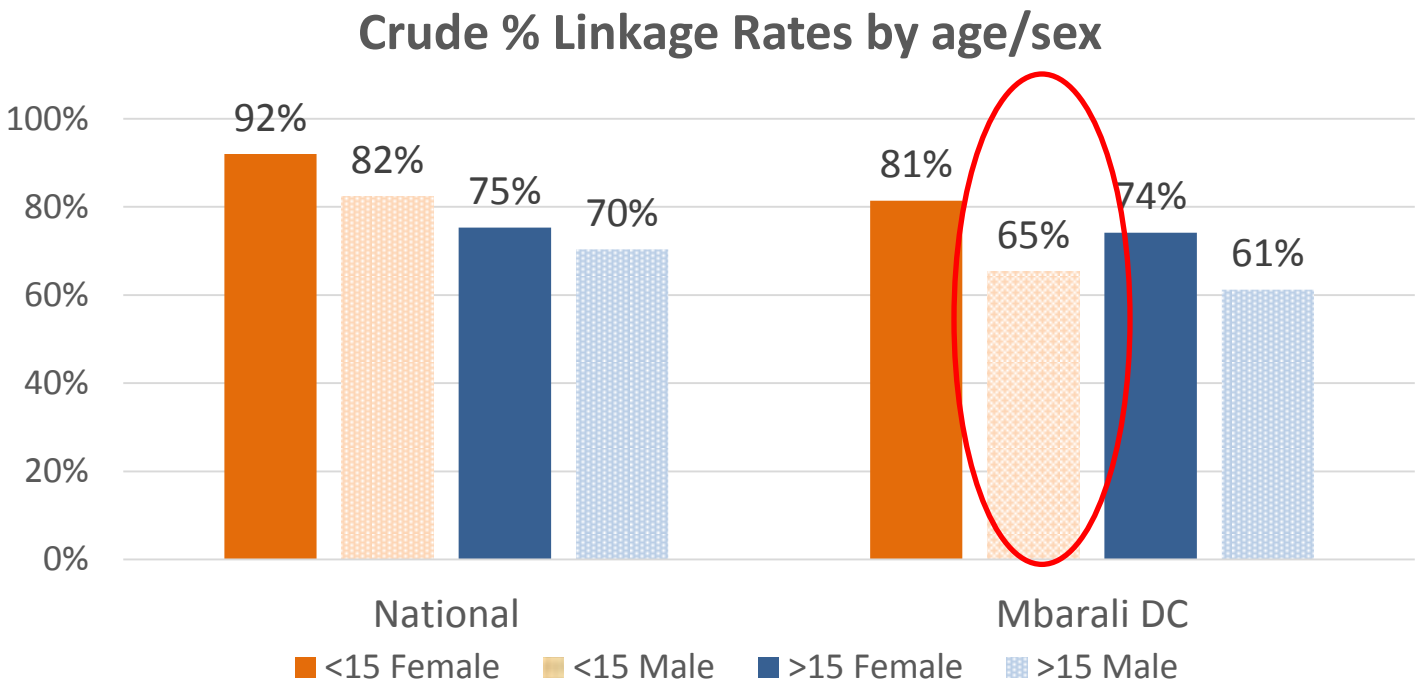
PEPFAR is planning to support all ARVs for HIV patients above the GF maximum support level in COP 2016



Linkage to care & ART retention

- Overall, linkage from HTC_POS to CARE_NEW was 79% in 2015
- Retention on ART at 12 months was 72%
- Sustained Councils
  - 51% (64/125) had linkage <75%
  - 78% (103/132) had 12-month retention <75%

Recommendation: Use council-level data to identify poor linkage and most impacted subgroups at highest risk



- In Mbarali DC, similar regional and national crude % linkage rate for women; BUT for men the rate is 5% and 9% lower respectively
- Possible challenges include mobile communities and challenges in community/facility linkages

Service packages for stable patients and patients with advanced disease

Stable patients

- Clinic visits 6 months
- ART refill 3 months
- Baseline CD4 and VL monitoring after 6 month then yearly

Advanced disease

- Monthly clinic visit and refill for ART
- Rapid initiation of ART
- TB screening followed by IPT and
- Intensive follow up

Differences in service packages across different councils (*e.g.*, scale up to saturation, aggressive scale-up, sustained)

Scale up councils only:

- Demand creation and frequency of supportive supervision
- Use of community support groups for patient tracking
- Training of HCW in scale up councils.
- Cervical cancer screening
- Prevention and response to GBV

COP 16: Priority Strategies to Reach 2nd 90

- Adopt Test and START for all (budgeted in PBAC per council prioritization)
  - Treat all pre-ART clients
  - “Come/Come back to treatment" campaigns for people who already know they are positive in the community
- Differentiated service delivery models to decongest clinics for stable patients
  - Biannual clinic visits for stable patients
  - 3 month refills (build on oral contraceptive model)
  - Decentralize ARV pick up at designated pharmacies within the community/village dispensaries
  - Explore distribution points outside the clinic using community health care workers; peer group pick-ups
- Integrate analysis in monthly partner meetings/quarterly data reviews

Impact of Unique Identifier on Second 90: Enhance linkage and retention

3rd 90

90% of all PLHIV on ART achieve viral suppression

3rd 90: Achievements and Opportunities

Achievements

- Successful “back to care” pilot campaigns
- Fully mapped and piloted viral load specimen transport system
- Web-based dashboard for real-time viral load and EID monitoring

Challenges/Opportunities

- Retention and adherence as we scale to pediatrics, pregnant and breastfeeding women, men, and now test and start
- Adoption of Test and START helps to change the framing to focus on the critical benefits of treatment on the individual’s health

What plans are in place for HIV drug resistance surveillance?

- **Plans for implementation of HIV drug resistance surveillance**
  - Finalization of Acquired, transmitted and pre-treatment HIV drug resistance protocols , submission to IRBs for approval followed by implementation
  - Revival of HIV Drug resistance Technical working group
  - Implementation of Early warning indictors in Rukwa, Mbeya and Katavi regions
- **What labs will PEPFAR support through FY16 COP?** 11 (VL Labs), 955 clinical/ testing laboratory
- **What initial labs will be supported** (i.e. for new patients)? 6 (VL Labs)
- **What labs will be routinely supported for follow-up, and with what frequency?** 11 Labs on quarterly basis
- **What labs will be supported for patients with advanced disease or failing ART?** 11 (VL Labs)

Plans to scale-up viral load and harmonize testing platform with EID, TB, and Hepatitis C

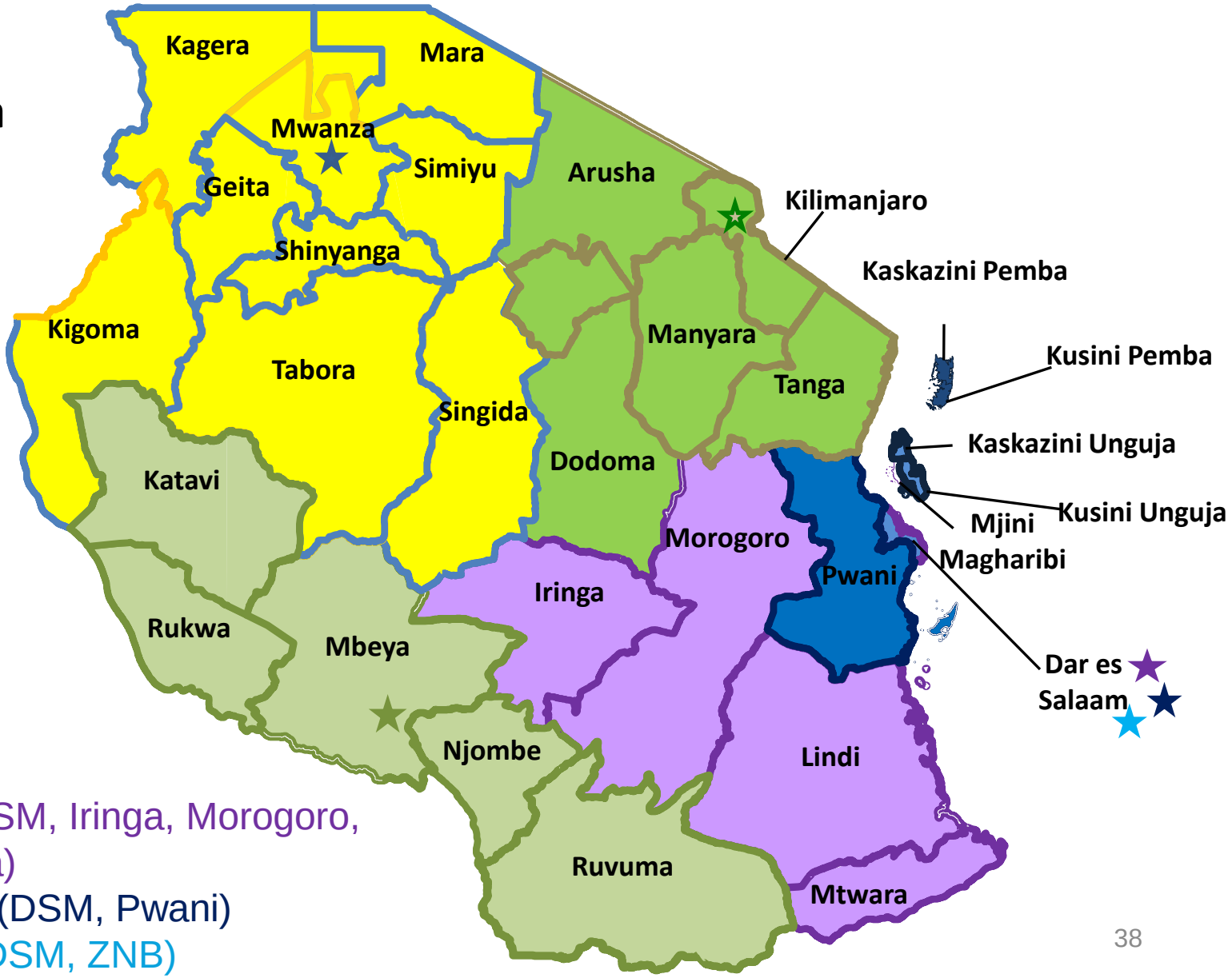
- There are 73 Gene Xpert machines currently used for TB which has the potential to be harmonized to also conduct EID, VL & Hepatitis C.
- Currently, there is an ongoing evaluation of two POC platforms in country: Alere Q for EID only and Cepheid Gene Xpert for both for EID and Viral Load.
- Current national clinical guidelines have all HIV positive individuals tested for TB and all TB positive individuals tested for HIV.
- A “hub and spoke” sample transport and results return system has been created. It includes 1) mapping of all facilities to hubs, 2) identification of courier systems (motorbike, public and commercial courier companies), and 3) development of a web-based sample tracking and results return system. The pilot began in October 2015 in the Lake Zone; results will inform the national scale-up to be implemented in COP15.
- Demand creation for VL will include training to Health Care Workers in all facilities in scale-up councils. Training materials for laboratorians, counselors, and clinicians have been developed and the training of TOTs has been completed.

Recommended strategy for HVL testing in the policy and guidelines

- As routine HVL monitoring is introduced, CD4 monitoring for patients on ART will no longer be performed to monitor patients on ART.
- Routine CD4 testing every six (6) months will be continued for pre-ART patients who require it for determination of ART eligibility.
- Baseline CD4 is recommended for “test and treat” populations (e.g.., pregnant and breastfeeding women, TB-infected patients, children <15 years).
- MOH plans to expand HVL testing capacity by adding more HVL testing facilities (either conventional or POC as technology evolves) in different parts of the Tanzania.
- The NACP at MOH will lead the HVL scale-up plan, and Regional Health Management Teams will manage the program in their respective regions.

Laboratories Performing EID/HVL Tests

Tanzania



- BMC Lab
- KCMC Lab
- MRH Lab
- MNH Lab (DSM, Iringa, Morogoro, Lindi, Mtwara)
- Temeke Lab (DSM, Pwani)
- NHLQATC (DSM, ZNB)

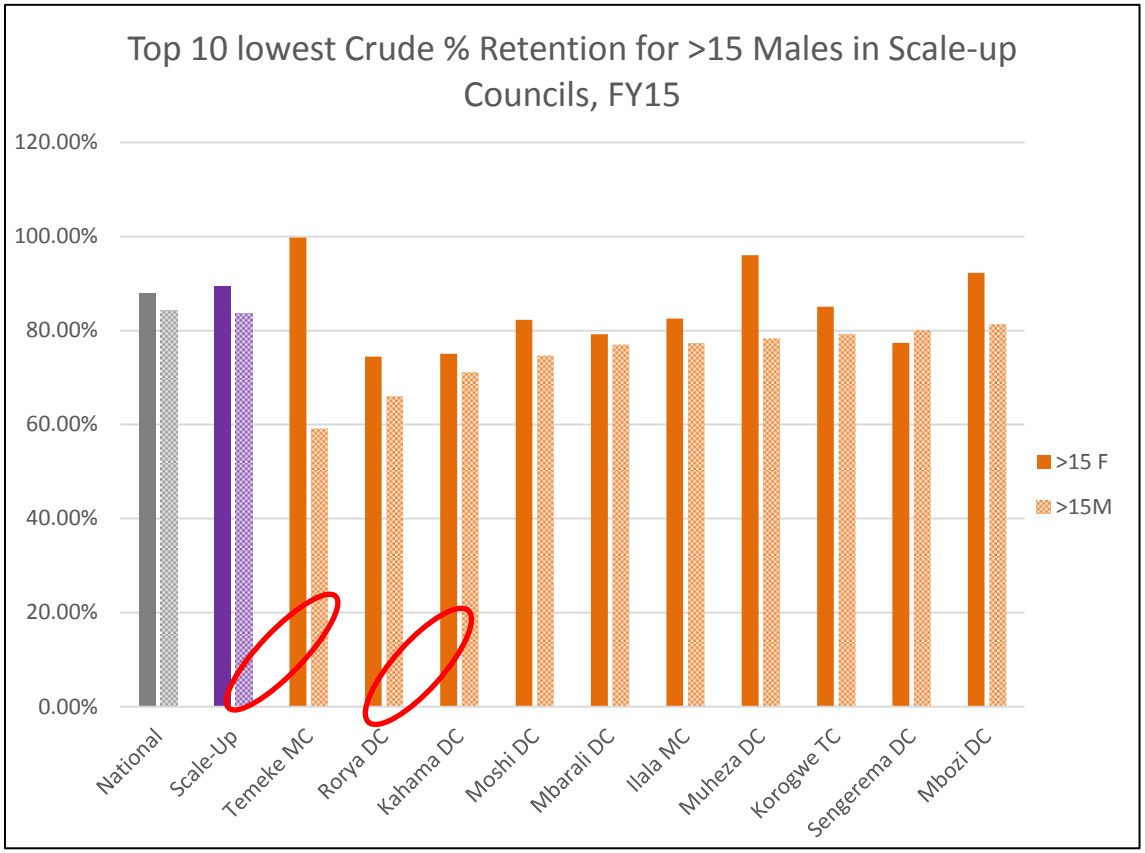
Viral Load Testing Volume

- Based on FY 15 program data, the estimated annual testing volume for HEID is 61,880 tests and HVL is 181,264 tests.
- The unused annual testing capacity is 202,696 for HEID and 243,056 for HVL as of February 2016.

	Testing Platform	FY 15 testing volume (A)	FY 15 testing capacity (B)	Unused testing capacity (B-A)
HEID	ROCHE (CAP/CTM)	61,880	264,576	202,696
HVL	ROCHE (CAP/CTM)	181,264	424,320	243,056

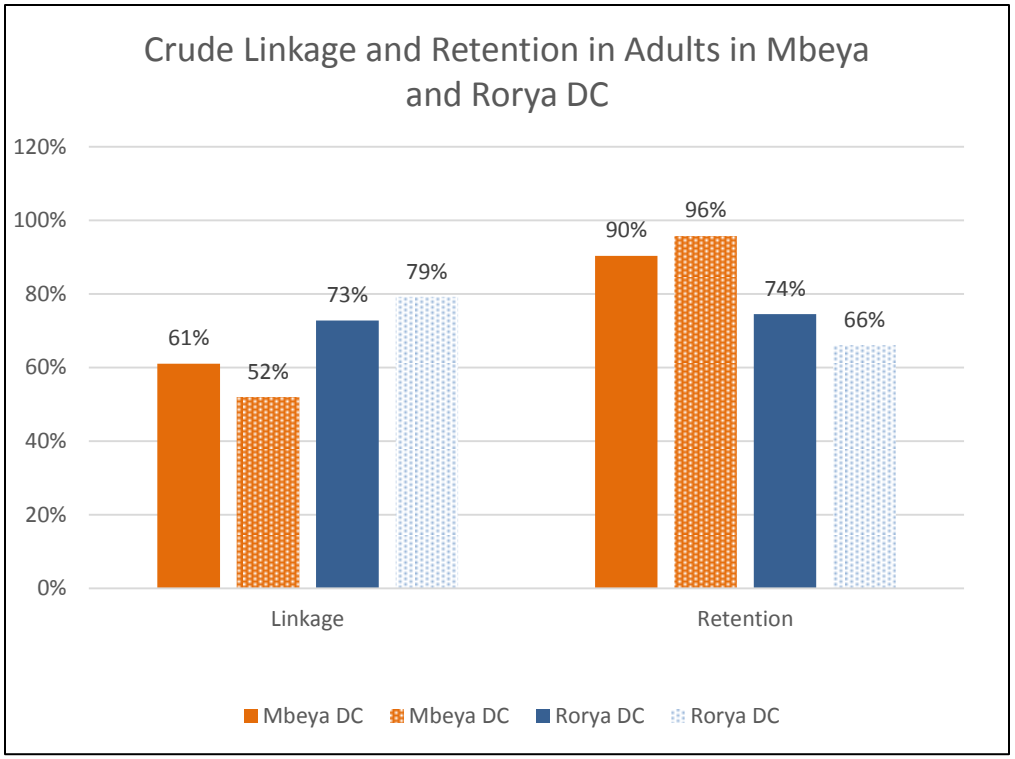
Use council-level data to identify poor retention and most impacted sub-groups

Retaining men in treatment is a challenge nationally. Using the gender analysis we can identify the 10 councils with the lowest retention rates and explore SNU-specific factors such as particular masculinity norms, mobility/employment or larger MSM communities which may contribute to even lower crude % rates [note DQA issues among females in Temeke to be explored]



Test & Start and DREAMS

Using sex-disaggregated data to drive geographic-specific programmatic decisions



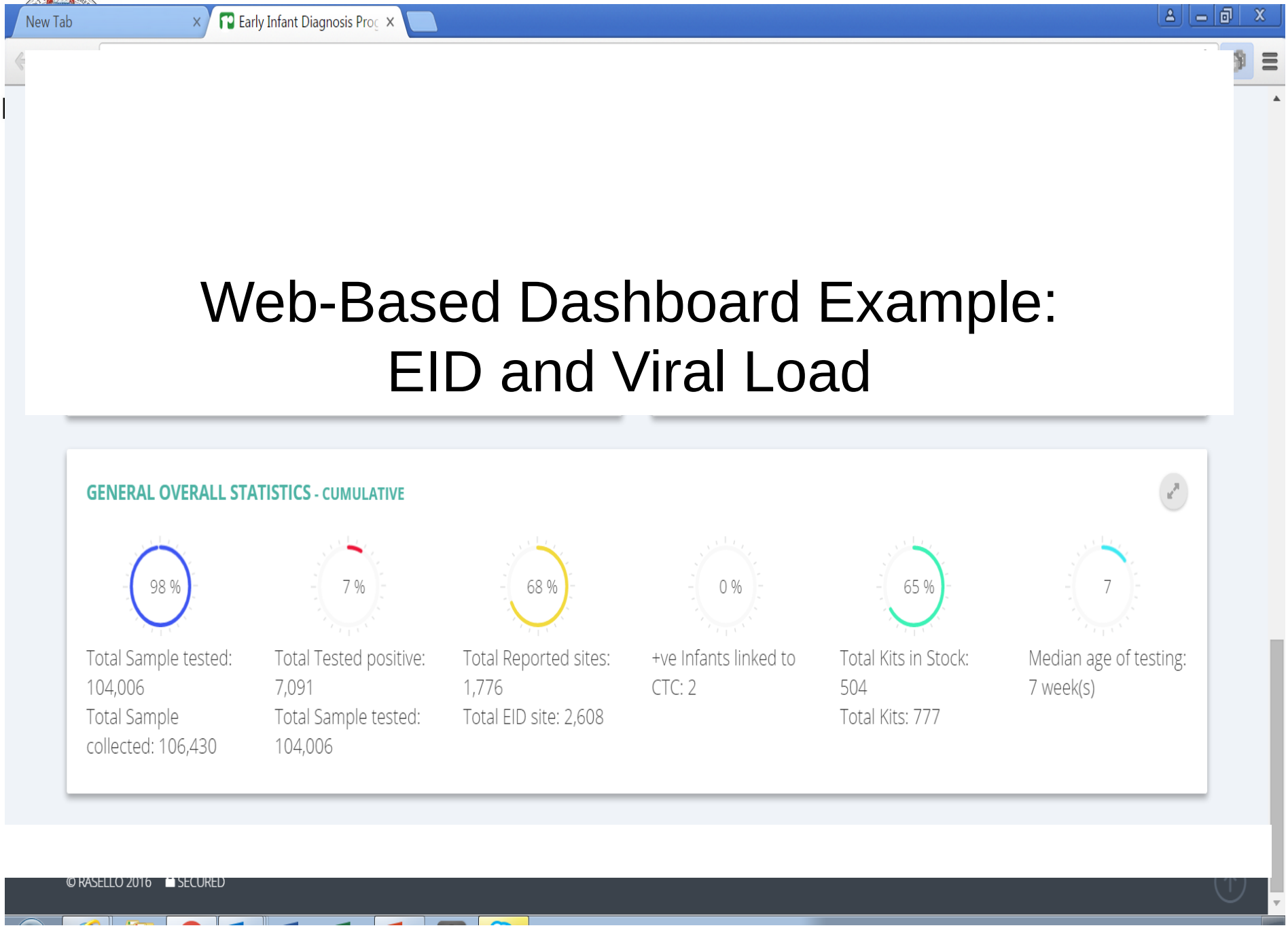
- In Mbeya DC (Mbeya) there are higher linkage rates for females than males but slightly lower retention rates for males than females
- In Rorya DC (Mara) there are slightly lower linkage rates for females than males but higher retention rates for females than males
- **Sex/age disaggregated data should drive programmatic decisions on how to focus linkage/retention efforts**

COP 16: Priority Strategies to Reach the 3rd 90

- Negotiated lease agreement for viral load machines (Cost per test: $40 ➔ $14)
- Continue to support development of M & E tools and web-based dashboard
- Scale up Sample transportation & results return system
- Focus on retention and adherence using facility and community resources

Impact of Unique Identifier on 3rd 90: Linkage and retention across the cascade; Linkage of VL results to patients

Web-Based Dashboard Example: EID and Viral Load



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COP 2016 Plan for HIV Epidemic Control

OTHER PROGRAM ELEMENTS

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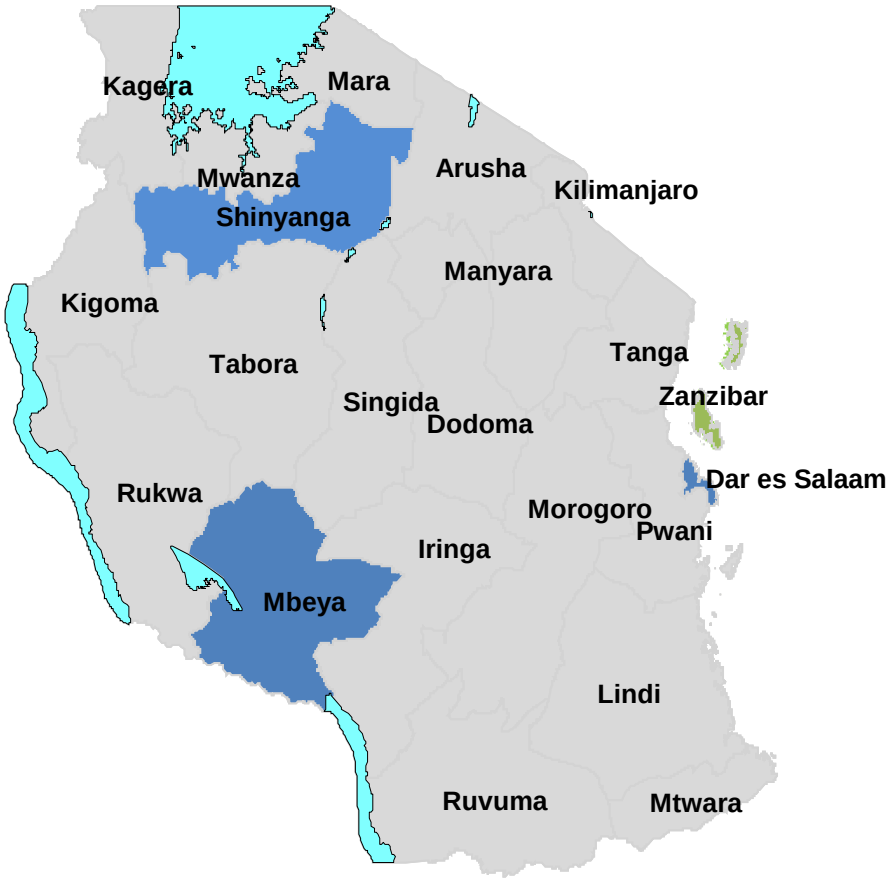
VMMC, DREAMS, GBV, OVC

VMMC age pivot

- Following an intensive modeling exercise in FY 2015, Tanzania data indicate that **VMMC focus on 10-29 year old males will obtain maximal impact** for both short- and long-term impact.
- Based on FY2015 data, 289.542 (47%) VMMCs were reported in the age band 15-29 while 10-14 yrs accounted for 278,700 VMMCs i.e. 45%. The latter age group is not prioritized for demand creation as they just turn up wherever a static or campaign program is scheduled. **Tanzania's focus on 10-29 is in alignment with the Tanzania VMMC Country Operational Plan that prioritizes 10-34yrs**.
- **Four DREAMS councils are also implementing VMMCs** while SNUs in Dar es Salaam are excluded based on the high VMMC coverage in that region.
- **Specific plans to realize the 15-29 age pivot include:**
  - Targeted communication & demand creation
  - Formulating service delivery models that address preference, convenience and seasonality
  - Outreach services – targeting workplaces and men in mobile occupations
  - Advocacy with GOT to prioritize 15-29

DREAMS



Progress to Date:

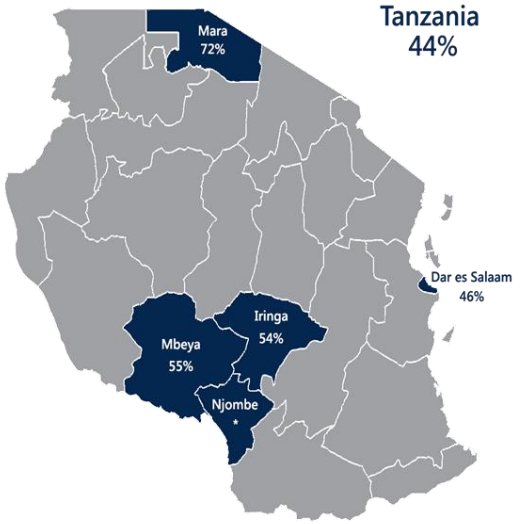
- New USG Population Cluster: AGYW, OVC, Key Pop TWG
- DREAMS IP workplans being finalized and included in quarterly reporting
- Implementation started by a majority of partners
- Updating the Characterization of Male Partners Strategy
- Social community norms strategy being developed for unified messaging across partners to be used for individual and group level interventions
- AGYW Index & Girl Roster to identify AGYW

Implementation Challenges:

- Delayed obligations to partners
- Definition of targets leading to very low targets but high EAs
- HIV testing Age of Consent
- Political transition and ministerial restructuring
- Scaling up test and treat
- Sustainability of program and ensuring scale up

Scaling up post-GBV care in FY16

	2014	% of total	2015	% of total
<15 Female	5028	7.6%	3467	7.2%
<15 Male	2322	3.5%	1923	4.0%
>15 Female	41135	62.4%	30820	63.8%
>15 Male	17402	26.4%	12074	25.0%



- **More females (72% of all adults and 64% of children) access facility-based post-GBV care than males** which corresponds to sex disparities across ages in survey- reported experiences of GBV (DHS, 2010; VACS, 2009)
- **The decrease in reported cases from 2014 to 2015 maybe be due to**:
  - Targeting
  - Tool roll-out challenges
  - Funding interruptions
- **Targeting for post-GBV is particularly challenging**, but as the program evolves and newer data emerges, targeting will continue to improve
- The GBVI rolled out in the 5 regions with the highest reporting of experiences of GBV (national prevalence of 44%) **but post-GBV care will be expanding to all priority SNUs in FY16**
- Overall the *Tathmini* Study in Mbeya region showed an increase in post-GBV service utilization, better training of clinicians, and greater community awareness of GBV and reporting options

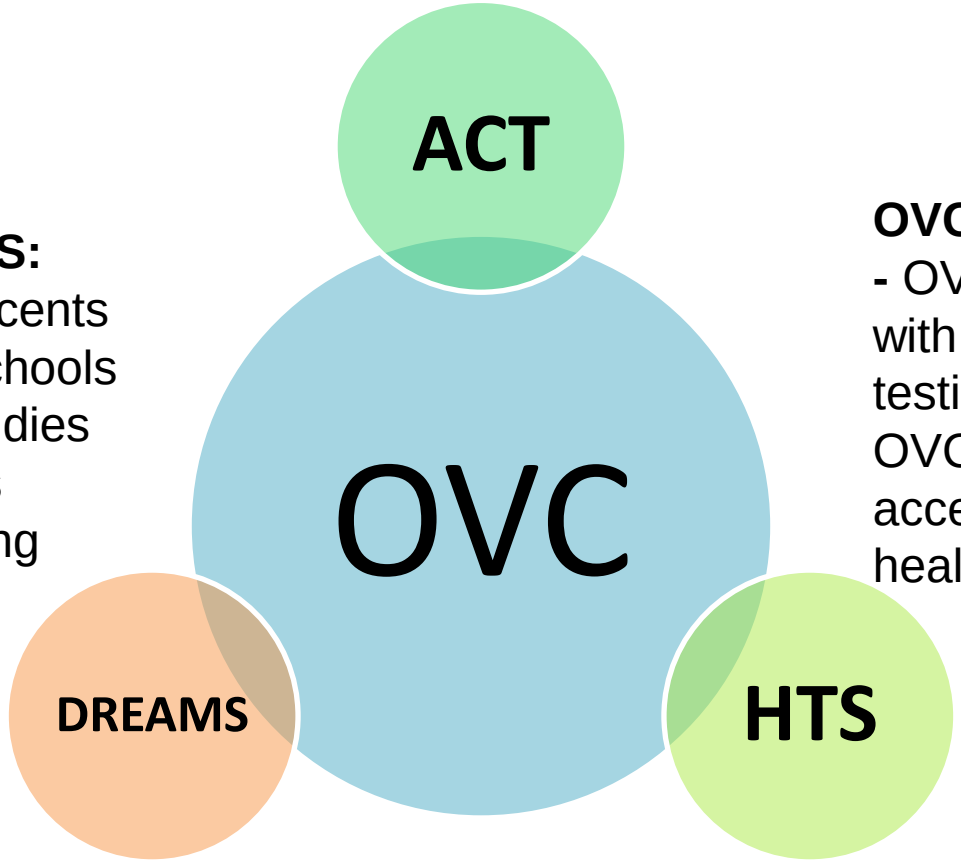
OVC Linkages

OVC and ACT

- Active case finding for LTFU of HIV exposed and positive children
- Q1-22-35% of enrolled OVC were referred from facilities-partners

OVC and DREAMS:

- Keeping adolescents 10-14 safe in schools
- Education subsidies and implements positive parenting



OVC and HTS

- OVC IPs will collaborate with HTS IPs to index testing for HIV exposed OVC who have never accessed HTS services at health facilities

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PROGRAM FINANCING

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Expenditure Analysis & COP 2016

Expenditure Analysis (EA)

- PEPFAR collects expenditure data annually from all implementing partners, broken down by budget category
- EA data show how funds are divided by program area
- When combined with program targets, these data help to determine how much money is spent per beneficiary by each partner and in each locality
- EA data reflect programming from the previous year's COP

EA Categories

EA Category	Full Name
FBCTS	Facility Based Care and Treatment Services
CBCTS	Community Based Care and Treatment Services
PMTCT	Prevention of Mother to Child Transmission
VMMC	Voluntary Medical Male Circumcision
HTC	HIV Testing and Counselling
PEP	Post-Exposure Prophylaxis
BS	Blood Supply
IC	Infection Control
LAB	Laboratory
OVC	Orphans and Vulnerable Children
GP-PREV	General Population Prevention
KP-PWID	Key Population – People who Inject Drugs
KP-FSW	Key Population – Female Sex Worker
KP-MSMTG	Key Population – Men who have sex with men and trans-gendered people
PP-PREV	Priority Population Prevention
MAT	Medically Assisted Therapy (Methadone)
HSS TO SI	Health Systems Strengthening for Strategic Information
SURV	Surveillance
Cross-cutting PM to SI	Program Management under Strategic Information
Cross-cutting PM to HSS	Program Management under Health Systems Strengthening
Cross-cutting SI to HSS	Strategic Information under Health Systems Strengthening

Distribution of EA FY15 Expenditure by Program Area

Table 3: Total PEPFAR Expenditures for Tanzania by Program Area and Fiscal Year

	2013		2014		2015	
Program Area	**Spend (USD)**	**% of Spend**	**Spend (USD)**	**% of Spend**	**Spend (USD)**	**% of Spend**
FBCTS	$80,129,097	28 %	$114,529,501	35 %	$92,315,785	32 %
CBCTS	$22,369,957	8 %	$21,592,836	7 %	$21,314,488	7 %
PMTCT	$38,241,101	13 %	$44,250,172	13 %	$34,287,339	12 %
VMMC	$16,911,731	6 %	$24,547,531	7 %	$30,980,993	11 %
HTC	$22,334,425	8 %	$21,186,124	6 %	$19,304,325	7 %
PEP	$956,327	0 %	$1,889,875	1 %	$1,121,369	0 %
BS	$7,244,136	2 %	$5,671,073	2 %	$3,837,895	1 %
IC	$4,828,516	2 %	$6,921,186	2 %	$3,291,534	1 %
LAB	$23,021,821	8 %	$24,460,221	7 %	$22,451,355	8 %
OVC	$24,160,135	8 %	$22,153,801	7 %	$20,135,106	7 %
GP-PREV	$23,883,902	8 %	$18,654,339	6 %	$8,060,290	3 %
KP-PWID	$4,521,346	2 %	$2,215,101	1 %	$2,121,360	1 %
KP-FSW	$2,436,345	1 %	$2,990,733	1 %	$2,823,815	1 %
KP-MSMTG	$912,676	0 %	$1,221,865	0 %	$1,190,321	0 %
PP-PREV	$6,612,211	2 %	$5,558,332	2 %	$10,751,445	4 %
MAT	$0	0 %	$615,783	0 %	$1,770,637	1 %
HSS TO SI	$8,779,619	3 %	$8,566,671	3 %	$9,463,831	3 %
SURV	$2,639,136	1 %	$1,091,842	0 %	$904,265	0 %
Cross-cutting PM to SI	$0	0 %	$385,457	0 %	$564,969	0 %
Cross-cutting PM to HSS	$894,540	0 %	$1,850,615	1 %	$1,759,498	1 %
Cross-cutting SI to HSS	$76,475	0 %	$860,160	0 %	$1,932,484	1 %
Totals	**$290,953,497**	**100 %**	**$331,213,219**	**100 %**	**$290,383,105**	**100 %**

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